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ASTHMA IN INFANCY

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THIS is an analysis of the records of 49 infants with asthma seen before the age of two.

These patients are unselected cases seen in private practice. Three cases were left out because of insufficient data; otherwise this represents the total number of records that I have of asthma, seen before two years of age.

Heredity

Sixteen patients had only paternal ancestors or relatives with asthma or hay fever.

Thirteen patients had such allergic inheritance on the maternal side only.

Ten had such allergy on both sides.

Ten had no known allergic inheritance.

Types of Asthma

Eight patients had attacks of asthma with good health between attacks. This group all did well promptly.

Eighteen had persistent wheezing, present for months without cessation. In this group were all the severe and intractable cases.

Twenty-two patients wheezed frequently, with or without definite attacks. Some of these patients were troublesome but all did well, some quickly and some slowly.

Severity

Of the infants with asthma, six were severe cases with underdevelopment, malnutrition and barrel chest, and one of these died.

From this it seems probable that asthma beginning before the age of two has a tendency to be more severe than that beginning later.

To get more evidence on this point we picked out 22 children of all ages with especially severe asthma. In these cases the average age on onset of the asthma was two years and one month. One hundred consecutive cases of asthma in childhood showed an average age of onset of three years and four months. This supports the thesis that the earlier the asthma begins, the more severe it is likely to be.

Scratch Tests on Patients Coming During the First Year and During the Second Year

22 Patients under 1 Year		*27 Patients Age 1-2*	
Egg	6	Egg	11
Alternaria	6	Potato	7
Aspergillus	5	Feather	6
Hormodendron	5	Aspergillus	6
Penicillium	4	Dust	5
Potato	4	Beef	4
Beef	3	Spinach	4
Chicken	3	Salmon	4
Pork	3	Dog	3
Spinach	3	Kapok	3
Orange	3	Grass	3
Salmon	3	Alternaria	3
Milk	1	Horm.	3
Dust	1	Chicken	3
Etc.		Lamb	3
		Corn	3
		Peanut	3
		Mustard	3
		Milk	1
		Etc.	

Interesting Suggestions:

There were few positive house dust tests, especially in the group under 1 year.

There were many positive mold tests, especially under one year.

There were few positive milk tests, in spite of the fact that milk is the most important food factor.

Foods	*Clinical Sensitivities to Foods, which were Demonstrated, Listed in order of their Frequency*	*Clinical Sensitivities to Foods which were accompanied by Positive Scratch Tests*
Egg	15	10
Orange	12	5
Milk	10	3
Wheat	8	5
Spinach	6	4
Fish	5	4
Lamb	4	2
Potato	4	2
Beef	3	2
Peas	3	2
Tomato	3	0
Oats	3	1
Etc.	Etc.	Etc.

continued on next page

*Presented as an exhibit at the Eastern Area meeting of the American Academy of Pediatrics, at Philadelphia, Pa., March 30-April 1, 1950.

The positive scratch tests and the clinical sentitivities were demonstrated during the course of treatment, and not necessarily before two years of age.

Foods	*Positive Scratch Tests to Foods Listed in order of Frequency*	*Positive Scratch Tests to Foods which were accompanied by Demonstrated Clinical Sensivitity*
Egg	18	10
Potato	11	2
Beef	10	2
Spinach	9	4
Wheat	7	5
Chicken	7	0
Fish	7	4
Orange	7	5
Corn	7	0
Pork	6	1
Peanuts	6	0
Lamb	5	2
Etc.	Etc.	Etc.
Milk	3	3

The striking point in these tables is that milk is a common cause of clinical sensitivity and an uncommon cause of positive scratch tests.

A Very Satisfactory One

J. B. 8 months of age

C. C. Snuffling and difficulty in breathing since 3 weeks of age.

F. H. Maternal aunt had eczema.

P. I. At first had mostly snuffling and rattling in throat with occasional dyspnea. For last 2 months frequently uncomfortable with dyspnea and much mucous discharge from nose and throat. Was diagnosed "Thymus" and given X-ray treatments.

P. E. Condition good. Nose, throat and lungs negative.

Positive Scratch Tests:

8 months

Cat	+	Egg	+
Dust	+	Spinach	+
Wheat	+	Potato	+

Clinical Sensitivities Demonstrated:

dust, wheat, egg, spinach, potato, fish, beets, orange.

Treatment:

Avoidance of house dust and the foods that upset him. Injections of house dust.

Result:

For 5 years had occasional wheezing with colds or with mistakes in diet. Now 9½ years has had no wheezing or respiratory difficulty for 4 years.

The Most Unsatisfactory One

C. F. 1½ years old.

C. C. Wheezing spells for 2 months.

F. H. Mother; hay fever. 2 paternal uncles; asthma.

P. H. Had eczema and still has it.

P. I. Two months ago had pneumonia and since has had 3 wheezy spells lasting several days each. Coughs all the time.

P. E. Condition, fair, coarse rales throughout lungs.

Positive Scratch Tests:

	1½ yrs.	2 yrs.	4 yrs.	8 yrs.
Cat	++		++++	+++
Dog	+++		++	+
Horse	0		++	+
Feathers	0		+	0
Dust	+		+	0
Timothy	0		++	+−
Egg	+++	+	++	+
Aspergillus	+		0	0
Beef	+++	++++	+	0
Chicken	0	0	++	+−
Lamb	+	0	0	+
Potato	+	+	+	+
Corn	++	+	+++	0
Peanut	0	0	+	+
Mustard			++++	+++
Birch			0	++
Camel			++	0
Cow			++	+

Clinical Sensitivities Demonstrated.

Dog, wheat, milk, egg, peas, spinach, orange, tomato, grapes, peach, apples, oats.

She has been wheezing continuously except that twice she was relieved for 4 months following a course of Penicillin. She has just started taking Penicillin again, a 3 day course and then 50,000 units twice daily p. o.

The One with the Longest Follow-Up

J. M. 1, 11/12 years

C. C. Asthma for 1 month.

F. H. Mother; asthma.

P. H. Eczema at 3 months.

P. I. Started wheezing a month ago and has wheezed continuously since. (Later it was worse in the summer, but was continuous all the year round.)

Positive Scratch Tests:

	2 yrs.	4 yrs.	7 yrs.	8 yrs.	11 yrs.	14 yrs.	23 yrs.
Timothy	0	0	0	0	0	++	+
Ragweed	0	0	+	++	+	+	0
Dog	++	0	++	++	++	+	0
Cat		0	++	+	++		0
Rabbit			0	0	0	+	0
Feather			0	0	0	+	0
Dust				++	++	+++	+
Egg		++	++	++++	+	+++	0
Orris		+	0	+	0	0	
Own Pillow (Kapok)						+	
Spinach	++++						
Potato	++						
Peas	++						

Clinical Sensitivities Demonstrated:

dust, ragweed, grass, dog, egg, spinach.

Result:

During the last year he was a little wheezy once, after contact with a dog.

One with Severe Vomiting

S. F. Age 1, 7/12

C. C. Wheezing attacks with dyspnea and cyanosis, and sometimes severe vomiting, occurring every week or two for 6 months.

F. H. Mother; asthma.

P. H. Much vomiting.

P. I. Wheezing attacks as described above with complete clearing between attacks.

P. E. Negative.

Scratch tests all negative.

Clinical sensitivities were not demonstrated but she seems much better on Mulsoy.

Treatment:

Avoidance of house dust, injections of house dust, molds and vaccine, and diet without milk.

Results:

Very little wheezing since starting treatment 2 years ago, none whatever for three months.

The Most Severe One

A. T. 22 months old

C. C. Asthma since 4 months of age.
F. H. Father; asthma. Mother; much bronchitis.
P. H. Eczema, still persists.
P. I. Asthma most of the time, worse in summer.
P. E. General condition fair. Slightly barrel chested. Lungs usually wheezy.

Positive Scratch Tests:

	22 months	4 yrs.	7 yrs.	9 yrs.
Horse	++++	++++	+	++++
Goat		+++	0	
Sheep		+	+	
Camel		++	+	
Cow		++++	++++	
Feathers	++++	++	0	0
Kapok	0	++	+	0
Dust	0	++	++	0
Timothy	0	+++	+	+
Ragweed	0	+	+	++
Alternaria	0	+−	+	+−
Aspergillus	0	0	+	+−
Hormodendron	0	+−	+	0
Wheat	0	++	+−	−
Milk	++	++	0	0
Egg	++++	+++	++++	+
Beef	+++	++	+	
Chicken	+	0	0	
Lamb	++	++	++	
Potato	+	+++	++	
Salmon	+	+++	++	
Corn	0	++	0	
Peanut	+++	+++	++++	
Pork	+++	+++	0	
Mustard	++++	+++	++	
Silk		++	0	
Fish Glue		++	+−	
Pyrethrum		++		
Tobacco		+++		

Clinical Sensitivities Demonstrated:

milk, egg, wheat, beef, lamb, pork, fish.

Treatment has been mainly by avoidance and injection all this time.

Result:

He still wheezes a good deal of the time, but appears normal, is a happy boy, and goes to school regularly.

The One Who Died

C. G. 22 months of age

C. C. Wheezing 4 months.
F. H. No allergy known.
P. H. Negative.
P. I. Has been steadily wheezy for 4 months with periods of moderate dyspnea.
P. E. Condition good. Lungs slightly wheezy.
Scratch tests were all negative.

No clinical sensitivities were demonstrated. Left town after 3 visits.

She was studied elsewhere and although she cleared in the hospital several times no continued improvement was made. She died at the age of 7 "All worn out from asthma" but no details are known.

Treatment

Inhalant allergens which are considered important in the individual case, and house dust and its producers and collectors are eliminated as far as possible.

Injections are given with extracts of all the inhalants which are thought to be of clinical importance. The dilution used at the start is not stronger than the weakest which will give a positive intracutaneous test. The intervals are usually 1 week for 4 injections and then are lengthened to 2, 3 or 4 weeks.

Some patients are treated with courses of Penicillin or Aureomycin. A few patients have been given Sulfadiazine for a period of months with good results. Pencillin and Aureomycin are now being tried on a few patients in daily doses for long periods.

Foods which by scratch skin test give large wheals with pseudopods and foods which are known to cause clinical allergic reactions are kept out of the diet. Other food allergies are sought for by provocative diet tests, in which the babies are put on a restricted diet, and then other foods are added one at a time, at intervals of 4 days. Particular pains are taken to test carefully for milk sensitivity.

Results of Treatment and Time According to Last Available Reports

	No Symptoms for 1 year or more	*Very slight wheezing once or twice during last year*	*Improved*	*Not Improved*	*Dead*	*No Report*
49 Patients	13	23	7	1	1	4
Results by Per cent	27%	47%	14%	2%	2%	8%
20 Patients followed more than 4 yrs.	4	10	4	1	1	

Conclusions

Asthma in infancy is common.

Asthma occurring in infancy tends to become severe and should be treated promptly and persistently.

The more severe cases show many sensitivities both to inhalants and foods. The less severe cases probably have many sensitivities but these are less easily demonstrable.

Treatment by avoidance or injection or both should be as complete as possible, and infections should be treated, especially with the antibiotics.

Treatment is more difficult than in older children, but the results in the long run are good, considering that many of these cases would become much worse if neglected.

OSTEOID OSTEOMA OF THE ASTRAGALUS

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OSTEOID OSTEOMA was not a recognized lesion until the advent of Jaffe's original paper in 1935. It is to him we owe credit for establishing this lesion as a distinct entity. Probably the first description of the pathological picture of this disorder was made by Bergstrand who, in 1930, described two cases and he was under the impression that the lesions, both clinically and pathologically were osteogenic sarcomas. Other investigators in the ensuing years have reported cases of osteoid osteoma.

In the October issue of the Journal of Bone and Joint Surgery of 1947, Dr. Mary S. Sherman of Chicago reported 30 additional cases of osteoid osteoma. In her paper she reviewed 158 cases of osteoid osteoma that were to be found in the literature and described the lesion as being predominantly found first in the tibia, then the femur and then the vertebrae, the astragalus numbering four on the list. It is noteworthy to observe that there are only 13 cases to date reported in the literature of this lesion of the astragalus.

Although the clinical picture of the disease has been reported before it is important to recall the physical findings of this disease; and it is only for emphasis in diagnosis that a brief summary of the chief symptoms of osteoid osteoma is now presented.

This disorder is much more common in the male than in the female. Of 127 cases that have been reported, 87 were males and the remainder females. The ratio of males to females is greater than 2 to 1. There has been only one case reported in the negro. Jaffe stated that the lesion has a predilection for adolescents and young adults. This has been verified by other workers.

The chief physical finding is that of tenderness, which usually can be definitely localized and which is exquisite in nature. The lesions in bones with little soft tissue covering may be accompanied by swelling; but rarely, if ever, are they warm, and never is the skin red. If the site of the lesion is near a joint, motion of that joint is often limited and painful. There is sometimes noted increased fluid in the joint space, and the findings may simulate a primary arthritis. In the spine, an osteoid osteoma produces all the signs of acute localized back pain, including associated muscle spasm and secondary postural imbalance. There are no systemic complaints or findings. The patients are afebrile and have normal blood counts. The X-ray picture of a mature lesion reveals a characteristic picture. There is an active nidus, which is usually small, round, or oval in shape, of reduced density. Within it one can see a small dense shadow, which represents ossification of the central portion. About this nidus is a thick dense shadow of sclerotic regional bone, and this bone is almost always present. If the lesion is at or in the cortex, the regional hypertrophy, especially along the periosteal surface, is much greater. The circumference of the shaft may be so greatly increased and the bone so sclerotic that the nidus is difficult to demonstrate by X-ray. The pathological picture is quite characteristic. One sees in the microscopic picture areas of cellular fibrous tissue, sometimes containing giant cells and many well-formed irregular trabeculae of osteoid tissue. Near the periphery of a section, sometimes one sees calcification of some of the trabeculae.

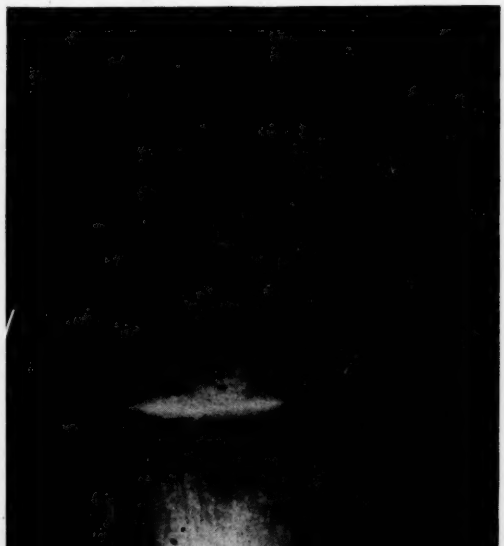
Treatment of osteoid osteoma is most satisfactory. For the immediate and permanent relief of symptoms, surgical excision is recommended.

Patient I. M., a 25 year old white male, was admitted to the Veterans Administration Hospital, Togus, Maine, on November 5, 1947, complaining of pain and swelling in the right ankle. He stated that in August 1945, he fell and turned his right ankle during an air raid in the Philippine Islands. There was considerable pain and swelling at this time. However, it subsided in a few days. Occasionally after that he would note mild pain and swelling after long walks or after standing long hours but not serious enough for him to consult a doctor. However, in February 1947, he began to notice almost daily occurrences of an aching pain in the ankle with a somewhat localized area of swelling on the inside of the ankle. This pain was particularly noticeable at night, frequently preventing him from falling asleep, or it would awaken him after he had fallen asleep. The pain and swelling had become progressively worse during the intervening months, so that in the past month or two it had caused him to limp slightly. Both the pain and the swelling were confined to a small area on the anteromedial aspect of the ankle.

There had been no known febrile episodes, nor were there any other symptoms.

Physical examination revealed a well developed, slightly built, undernourished white male, who was not acutely ill. Examination was entirely negative except for a moderate, diffuse, soft swelling on the medial aspect of the right ankle joint, just distal and anterior to the medial malleolus. This area was exquisitely tender to palpation, but there was no redness or increased surface heat. There was a normal range of motion except that forced eversion elicited pain. All of the routine clinical and laboratory examinations including urine, CBC, and Kahn test were within normal limits. Sedimentation rate was two mgms. per hour. X-ray of the chest was negative. A patch test for TB was negative. X-ray of the right ankle revealed an active nidus, small, round, about one cm., lesion of the astragalus. Within this nidus, was seen a small dense shadow, which represented ossification of the central portion. At this time we suspected that we were dealing with an osteoid osteoma of the astragalus, and an operation was performed.

Under spinal anesthesia, the right leg and ankle were prepared and draped in the usual fashion. A tourniquet was applied to the upper thigh, and a small curved incision was then made over the medial aspect of the ankle joint. The incision was directed through the subcutaneous tissue, through the joint capsule and synovial membrane, encountering a small circumscribed area, the size of a ten-cent piece, on the articular surface of the talus, on its medial aspect. This area was softer than the surrounding bone and was spongy and congested in appearance, pinkish and granular. On using a bone curette, the small area was excised in its entirety. The wound was then closed with interrupted black silk. A plaster cast was applied from the tibial crest to the knee down to and including the toes. A specimen of the lesion was sent to the laboratory. The pathological report follows: Gross appearance of the lesion showed a small nodule, granular and pinkish in color, surrounded by spicules of bone. The microscopic picture presented a central nidus of sclerosing bone, surrounded by osteoid tissue and a dense fibrous stroma. Following operation, the very next morning, the patient stated that his pain was completely gone and he felt very well for the first time in three years with complete relief of symptoms. He remained free from pain up to the time he left the hospital on January 29, 1948. A month later, after the patient had gone home, about February 28, a personal communication was received from the patient, stating that he still is enjoying very good health and has not had any recurrence of his pain.



Roentgenogram of right ankle. Arrow points to lesion of osteoid osteoma.

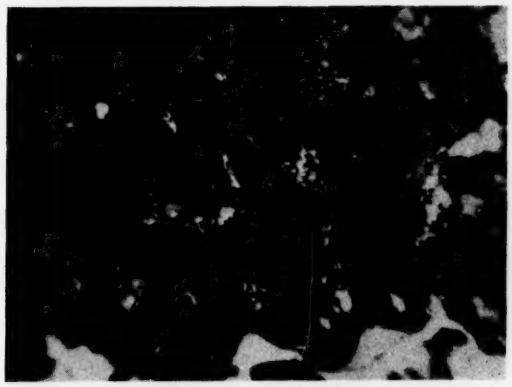


Photo microscopic picture of osteoid osteoma

Summary

A case of osteoid osteoma involving the astragalus of the right foot cured by surgical removal is reported.

This represents the thirteenth such case reported in this locality.

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SYMPATHETIC NERVE BLOCK

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SYMPATHETIC nerve block is a paravertebral injection of the sympathetic nerves or their ganglia. It is a comparatively new therapeutic and diagnostic procedure. Since the original work of Lawen (1923) with procain and Swetlow (1926) with alcohol in blocking sympathetic nerve fibers, there has been only a mild interest in this valuable form of therapy. Many patients with an intractable type of burning or aching pain following an injury of some kind to an extremity can now receive spectacular relief by blocking abnormal sympathetic reflex mechanisms. The procedure has been simplified in order to obtain the maximum sympathetic response with minimum amount of discomfort to the patient. Blocks for upper extremities are obtained by injecting the proper fascial plane in the neck (region of fifth cervical vertebra) in order to infiltrate the stellate ganglion. This technique eliminates the danger of pleural puncture that may occur if the stellate ganglion were injected directly. The successful use of stellate ganglion block for cerebral thrombosis has been reported in the literature[1]. Blocks for lower extremities are made paravertebrally by a dorsal approach. The patient's discomfort can be minimized if the operator refrains from hitting the periosteum of the body of the vertebra too many times.

The anesthetic solution that will give the more lasting effect with least toxicity is the one desired. In our hands *Metycaine 1½% has given us better results. This was particularly noted in our previous paper on brachial blocks[2]. The total amount of solution should be kept at a minimum to prevent infiltrating adjacent somatic nerves. A stellate block requires only 5 c.c. of solution and a lumbar sympathetic block, 10 to 20 c.c.

Reflex Sympathetic Dystrophy

Severe pain of an extremity following war injuries was first described during the Civil War by Weir Mitchell. He called this post-traumatic syndrome a Causalgia. Since that time, the same clinical syndrome has been described as reflex sympathetic dystrophy, post-traumatic dystrophy, shoulder-hand syndrome[3] and in far-advanced cases with bony changes, it is called traumatic osteoporosis or Sudek's atrophy.

The cause of this syndrome is trauma but the severity of this trauma may vary from a simple bruise to a crushing injury of an extremity, resulting in a hyperactive sympathetic reflex as shown by vasomotor and trophic disturbances. Other immediate types of injuries may be herpes zoster, frost bite, thrombophebitis or chronic occupational strain.

In those cases in which the pathological process persists, the condition becomes progressively worse resulting in varying degrees of pain, but the vasomotor and tropic disturbances become more severe. The skin of the extremity will become mottled, cold and sweaty, or it may be hot at the onset with some subcutaneous edema. Then atrophy of the skin with fibrosis of muscles and stiffening of the joints may follow. The fingers will become thin and tapering. If the condition continues, atrophy of the bone will result, giving the x-ray a moth-eaten appearance.

It appears that the patients' emotional instability such as nervousness, excessive sweating and tachycardia is more closely related to sympathetic dystrophy, rather than the severity of the injury.

Although sweating is a salient feature of these sympathetic hyperactive states, it is well-known that an injection of adrenalin will not produce this in a person. The reason for this has been shown by Dale and Feldbert (1934) who noted that post-ganglionic sympathetic fibers to sweat glands are cholinergic. Thus, atropine, which is a para-sympathetic inhibitor, can abolish the sweating by blocking the cholinergic transmission.

Raynaud described a syndrome in 1862 which now bears his name. White and Smithwick[4] agree with his theory of vaso-constriction due to sympathetic over-activity but Sir Thomas Lewis prefers to attribute the origin to a local action in the musculature of the blood vessels. In Raynaud's Disease, the diagnosis should be confirmed by a sympathetic nerve block and the treatment required

* *Appreciation is extended to Eli Lilly Co. for an experimental supply of Metycaine that was used in these cases.*

is a sympathectomy. If the sympathetic block is unsuccessful, the sympathectomy is not likely to prove successful[5].

Oschner and De Bakey[6] (1941) have recommended the use of sympathetic blocks to relieve the venous and arterial spasm in thrombophlebitis. White and Smithwick have used sympathetic blocks for hyperhidrosis (excessive sweating). Similar blocks have been used successfully for herpes zoster by blocking the sympathetics at the level of the involvement. Phantom limb has been treated by sympathetic blocks, but not all patients are benefited by this procedure.

The physiology in these disturbed states is not clear. Livingston[7] has described the internuncial pool in the spinal cord, resulting in a barrage of impulses from a focus of irritation, as an explanation of the abnormal state. Some authors have attempted to inject the focus of irritation or the trigger point without conclusive evidence that the same disturbed dysfunction occurs in every situation. This abnormal sympathetic excitation or exaggerated reflex is located within the internuncial pool and must be interrupted by a sympathetic block. In those cases that are successfully treated with sympathetic block, each sympathetic block will be followed by a longer interval of relief. The original block may interrupt the vicious sympathetic cycle for two or three hours and the next one may last the entire day, until it will be noted that the patient will get relief for two to three weeks after his fourth or fifth block. The sympathetic blocks should be repeated at longer and longer intervals of rest but should not be delayed long enough for the sympathetic over-activity to return. It has also been found that a single sympathetic block may permanently interrupt this over-activity. On the other hand, if each successive sympathetic block gives only the same short period of relief, then it must be assumed that a sympathectomy is required to permanently knock out this sympathetic bombardment.

The skin temperature changes following sympathetic blocks are variable, depending on the degree of vasomotor disturbance. The average skin temperature rise, following a block in a normal extremity, is about eight to ten degrees. In those conditions with cold, clammy extremities, the rise may be from twenty to twenty-five degrees. In the hot and swollen extremities, there will be little or no temperature rise and therefore is no indication of the success of a block. Thus, either a skin temperature rise of twenty degrees or the spontaneous relief of pain is a good indication of the presence of sympathetic over-activity. Both responses may or may not occur together. Pharmaceutical houses have recently publicized certain drugs claiming autonomic and sympatholytic action for this condition. The results are not convincing. In my experience, satisfactory results were not obtained in the presence of these drugs until sympathetic nerve blocks were administered.

The following are summaries of case histories in which only the salient features have been included.

CASE I — Mrs. M. D. Age 54

Seen with painful Herpes Zoster in region of right breast and axilla of eleven days duration. Patient had been treated with Vitamin B both by mouth and intramuscularly without improvement. Codeine and Demerol were required to ease the pain.

Patient was given a right dorsal sympathetic block at T2, T3 and T4 with immediate relief of pain which lasted five days. The patient received her second sympathetic block which relieved her for ten days. She was blocked three times more on alternate days and at the end of her injections, patient admitted relief of the intense pain although a mild soreness persisted. The treatment had no effect on the herpetic rash.

CASE II — Mrs. J. H. Age 45

Patient was seen seven months post-operatively following a radical breast amputation on her right side. There was burning pain of the wrist and forearm and swelling of the entire extremity including the fingers. Hyperesthesia was present. The color, temperature and radial pulse were the same in both arms. This patient was given a right stellate block with immediate relief of pain. Temperature rise was only minimum. This was the first relief from pain since her operation. Four days later the patient noted the complete loss of edema and the continued absence of her previous pain. Thereafter, the stellate blocks were continued at weekly intervals for three more times and the patient continued to be symptom-free. The edema of the extremity did not return.

CASE III—Mrs. H. M. Age 69

A controlled diabetic was seen with burning pain in left foot with a large ulcer (size of half dollar) on her heel. A similar condition started in her right foot nine months ago which steadily grew worse, requiring amputation at the mid-thigh. Patient now refused any type of operation. Repeated sympathetic blocks were done at D12, L1 and L2 for her left leg with rapid improvement. The edema disappeared completely, the pain was relieved and the ulcer healed to the size of the head of a pencil. It is four months now since her original visit and the patient returns periodically for a sympathetic block when there is evidence of the return of her burning pain or swelling.

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CASE IV — Mrs. E. S. Age 54

Patient seen with a post-herpetic neuralgia of ten weeks duration involving the distribution of the third thoracic nerve on her right side, requiring large doses of morphia. There was a history of herpetic lesions of the skin but at present, the only evidence was a pigmented linear distribution. Patient was given a dorsal sympathetic block at D2, D3 and D4 with immediate relief of pain lasting twenty-four hours. Each successive block gave longer and longer periods of relief. At the end of her sixth block, the pain had completely disappeared. However, five weeks later, the patient returned complaining of severe pain, this time, along the sixth thoracic nerve on the same side. There was no skin erruption. Three more blocks at five day intervals relieved her pain and patient has been symptom-free for four months.

CASE V — Mrs. A. W. Age 39

Patient seen with a post-traumatic sympathetic dystrophy, stage 1, of right wrist and forearm. Patient has been treated for past two years, following severe trauma to right wrist, with diathermy, whirlpool baths and splinting in a plaster cast. Patient complained of a "tooth ache" type of pain with coldness and sweating but no burning. Patient was given a series of right stellate blocks, anterior approach, at C5 with typical Horner's Syndrome resulting each time. After each block, patient received longer and longer periods of complete relief of her pain. Patient began to pronate and suppinate her hand freely without the distress she noted previously. After her sixth block, it was noted that patient had complete relief for seven weeks and she could go about her household duties without distress. Patient now has gone twenty-one weeks without pain, following her tenth stellate block.

CASE VI — Mrs. E. T. Age 49

A controlled diabetic was seen with post-thrombophlebitic sympathetic causalgia of right thigh. She complained of an ache and at times a burning pain of her right thigh for the past seven months, especially after walking. Patient was given a series of three sympathetic blocks at D12, L1 and L2 with immediate relief of pain. Skin temperature readings showed a 13 degree rise in her foot following the blocks. Patient continued to have complete relief for four months without further blocks, after which time patient complained of a mild recurrence of the pain. She was given two more sympathetic blocks at five day intervals with complete disappearance of her pain. Patient has now been symptom free for seven months following her last block.

CASE VII — Mrs. H. W. Age 63

A controlled diabetic seen with pain in left foot with a gangrenous big toe involving the distal phalanx. No pulsation could be felt in the foot. One year ago, patient had a similar picture of her right foot and she had a right sympathectomy done without any benefit. The gangrenous big toe became worse and she was subjected within a short time to a mid-thigh amputation. In spite of advice by surgeons to have another sympathectomy on her left side with a trans-metatarsal amputation for this new episode, she refused any type of surgical intervention. The unsuccessful results of the sympathectomy on her right side was a bitter experience for her. However, she consented to a short series of sympathetic blocks. On the basis of encouraging a rapid collateral circulation, she was given left lumbar sympathetic blocks at D12, L1 and L2. There was no appreciable rise in skin temperatures but there were longer and longer periods of relief of her pain. At the end of her seventh sympathetic block, it was noted that her foot was warmer and the gangrenous big toe had sloughed off and fresh granulations were forming beneath. Soon the skin edges healed over, leaving a small draining sinus. The pain had disappeared and the patient began to walk on crutches. Her injections were continued with longer intervals between each sympathetic block. At present, patient returns every eight weeks for a sympathetic block. It is seventeen months since her original visit. She now has full use of her left leg and is ambulatory with the aid of an artificial right limb.

CASE VIII — Mrs. M. F. Age 32

Patient seen with post-traumatic sympathetic dystrophy, stage 2 right foot, with story of an injury ten months ago. She complained of coldness and swelling of right ankle and foot, but no sweating. Patient had been treated with whirlpool baths and for the past six months was wearing a cast with no improvement. She was given a sympathetic block at D12, and L1 on right side with immediate relief. Skin temperature readings showed a temperature rise of 17 degrees in that foot. This was repeated every fifth day and it was noted after her fourth block that her symptoms had not returned and the ankle swelling had completely disappeared. Further treatment was discontinued and there was no recurrence of her pain. She has now been symptom free for the past thirteen months.

CASE IX — Miss M. J.

Patient was seen with a sympathetic causalgia of right lower leg and foot with coldness and swelling of two years duration. Patient had received an open reduction for a compound fracture at that time and since then complained of a throbbing and burning pain even while at rest. X-rays showed

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REMOVAL OF A MALIGNANT KIDNEY TUMOR THROUGH A THORACO-ABDOMINAL INCISION

Report of a Case

JOHN F. STREKER, M.D., ALBERT H. JACKVONY, M.D.,
WILLIAM A. MCDONNELL, M.D., and JOHN E. FARLEY, M.D.

The Authors. *John F. Streker, M.D., Visiting Urologist; Albert H. Jackvony, Visiting Surgeon; William A. McDonnell, M.D., Physician-in-chief, Anesthesiology Department; all of St. Joseph's Hospital, Providence. John E. Farley, M.D., Resident, Charles V. Chapin Hospital, Providence.*

THORACO-ABDOMINAL APPROACH to kidney tumors was developed and first reported in this country by Chute and Soutter[1] of Boston. However, a single case in 1946 was operated by this route, unknown to Chute and Soutter, and reported in the American Journal of Urology by Mortenson[2] of Australia in December, 1948.

Thoraco-abdominal nephrectomy offers the following advantages:

1. Excellent exposure, which greatly facilitates nephrectomy in difficult large kidney tumors. In such cases the blood supply is very rich, and tumor tissue readily spreads, especially through the renal vein. The vein and entire pedicle is readily delineated and may be easily ligated without handling the tumor mass.

2. The perirenal fat pad is removed intact with the kidney, and local lymphatic metastasis, which is very common in kidney tumors by the time they are diagnosed and operated, may be removed. This is in contrast to the lumbar approach, which offers no such opportunity. In a series reported by Chute and Soutter in December of 1949, all but 8 of 20 cases showed such local metastasis.

The following is a report of a case in which this technic was used:

M. C., a 61 year old white married female, was admitted to St. Joseph's Hospital on 12/19/49 complaining of weakness, vomiting, and weight loss. The patient stated that she was well until approximately one year prior to admission, when she noted weakness, drowsiness and fatigue. She consulted her family physician four or five months prior to admission because of increased severity of symptoms and the onset of occasional nausea and regurgitation. She had lost 18 pounds in the last eight months. A gastro-intestinal series was performed outside the hospital and was not remarkable except for pylorospasm. A mild hypochromic microcytic anemia was also discovered. She had received liver and iron but had not responded to treatment. Her appetite was only fair, but there was no disturbance in bowel habits. It was further revealed that two months prior to admission she had retention and hematuria on one occasion. There were no other complaints.

The past history showed the usual childhood diseases. There were no previous serious illnesses, operations, or injuries.

The family history was non-contributory.

The system review was essentially negative.

On physical examination the patient was a pale, fairly well developed, poorly nourished, white, middle-aged appearing female in no acute distress. The skin was pale, but was clear, cool, and dry. Her pupils were round, regular, equal, and reacted to light and accommodation. Sclerae were clear. The conjunctivae were pale. She appeared to have incipient cataracts bilaterally. Ophthalmological examination essentially negative. Nose and ears were without abnormality. There was edentia. Her tongue was reddened but not smooth. The throat was clear except for minimal injection in the right posterior pharynx. Her neck was supple. There were no glands palpated. The thyroid was not palpable.

The chest and lungs were clear to percussion and auscultation. The heart was normal in size, rate and rhythm. There was a Grade I apical systolic murmur, not transmitted.

Palpation of her abdomen revealed a mass slightly movable, firm, the size of an orange in the left upper quadrant. The abdomen was otherwise without abnormality.

The neuromuscular system showed no abnormalities. There was no limitation of joints. There was one plus pitting edema of her ankles bilaterally. There were no palpable glands.

Initial laboratory work showed an essentially normal urine. Blood studies: Hematocrit of 27 mm. with a Sahli hemoglobin of 60% or 9.36 grams; white count 9,800; red count 3,450,000; with a differential of 78 neutrophiles, 18 lymphocytes, 3 monocytes and 1 eosinophile. The mean corpuscular volume was 79, and the mean corpuscular hemoglobin 23. The mean corpuscular hemoglobin

continued on next page

concentration was 22. The fasting blood sugar was 90 mgs. Blood urea nitrogen was 16.3 mgs. Chlorides 536 mgs. Blood protein 3.69 gms. Albumin 2.80 gms. and globulin of 0.89 gms.

X-ray examination of the chest revealed minimal sclerosis of the aortic arch. The lung fields were clear. Examination of the renal structures by KUB film revealed the right kidney to be normal in size, shape and position. There was a marked enlargement of the upper half of the left kidney. Film after the intravenous injection of the dye revealed the calices, pelvis and upper portion of the right ureter to be well visualized. The lower portion of the right ureter was not visualized at any time. On the left side only the lowermost calices were visualized at any time. No dye was seen in the upper distended portion of the left kidney. CONCLUSION was that the findings were consistent with a large tumor mass in the upper left kidney which was most probably neoplastic although the possibility of a cyst could not absolutely be ruled out.

Examination of the large bowel by barium enema revealed no evidence of bowel pathology.

Examination of the skull revealed an area of increased bone density in the right frontal bone which measured approximately 1½ x 2 cm. in size. It did not have the usual appearance of metastasis but was osteoblastic in character. However, the possibility could not be ruled out. The lesion had more of the appearance of an osteoma. There was no other evidence of pathology in the skull.

Examination of the pelvis and lumbosacral spine revealed no evidence of metastasis.

Bone marrow studies performed revealed essentially no pathology.

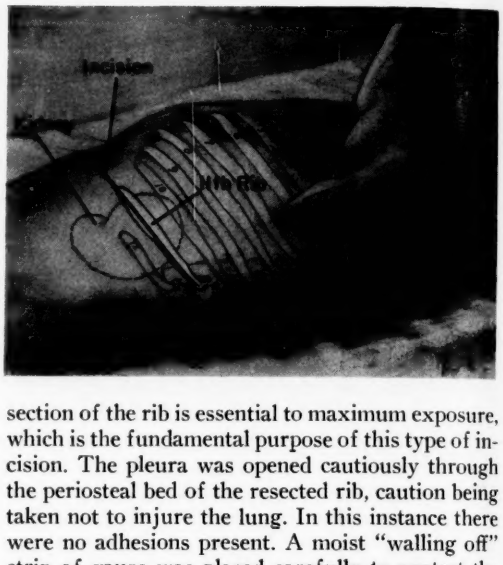
The patient was given four whole blood transfusions totalling 2,000 cc. over a period of two weeks with a response demonstrated by counts which revealed 85% Sahli hemoglobin; 11,350 white blood cells; 4,350,000 red blood cells; with a differential of 65 neutrophiles, 26 lymphocytes and 5 eosinophiles. Her serum protein also responded with a total of 6 grams and albumin of 4.35 grams and globulin 1.65 grams.

The patient was operated on 23 days after admission.

Operative and Anesthesia Technic

The patient was medicated with Pantopon Grs. 1/6 and Scopolamine Grs. 1/150, 1½ hours preoperatively and Nembutal Grs. 1½, 1 hour preoperatively. Cyclopropane anesthesia started, followed by ether.

The incision started from a point about 1 cm. lateral to the spinous process and was extended downward over the 11th rib and continued anteriorly in the same direction, to the lateral border of the rectus muscle. The next step was a complete subperiosteal resection of the 11th rib. Complete re-

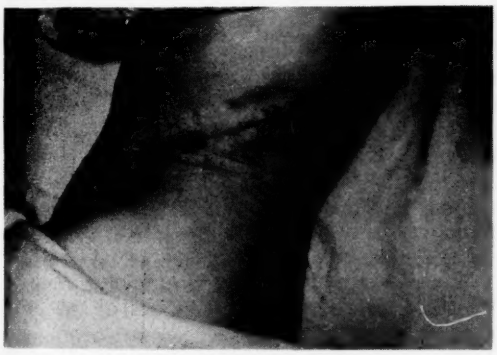


section of the rib is essential to maximum exposure, which is the fundamental purpose of this type of incision. The pleura was opened cautiously through the periosteal bed of the resected rib, caution being taken not to injure the lung. In this instance there were no adhesions present. A moist "walling off" strip of gauze was placed carefully to protect the lung, which was kept about 80% expanded. The phrenic nerve was located passing down over the pericardium, but in this instance the decision was made not to crush the nerve. Next, the diaphragm was opened in line with the incision. This incision was carried anteriorly through the obliques and transversus abdominus muscles until the lateral border of the rectus was reached. A spreading retractor was placed in the wound between the 10th and 12th ribs. The tumor mass together with the spleen bulged directly up in the center of the wound. The spleen in this case was enlarged and the decision was made to remove it. The colon was carefully freed from the tumor mass and a large, thickened, tumor-filled renal vein was exposed. This tumor mass in the vein was gently milked back, it having extended to the vena cava, and the vein was then carefully ligated and sectioned. The artery was then sectioned after being carefully ligated. A large and entirely separate second renal vein going to the upper pole of the kidney was clamped and ligated. The original renal vein in this instance was non-functioning and packed solidly with tumor tissue. There was no tumor tissue in the functioning anomalous renal vein. The ureter was clamped, ligated and sectioned below the uretero-pelvic junction. The entire tumor mass with its perirenal fat pad was removed. In this case there were a few peri-aortic lymph nodes present and these were dissected free and removed. Closure was then carried out. The peritoneum was closed with a running #1 plain catgut suture. The diaphragm was closed with interrupted heavy silk sutures. The pleura was closed with interrupted silk sutures. The last two sutures in the pleura were not tied until the lung was completely ex-

panded. The muscles were closed with interrupted #1 chromic sutures and the skin with silk.

The specimen was described grossly as a mass 16 cm. in length, 13 cm. in thickness and 10 cm. in width. In the hilus was a lobulated, pale brown, firm tumor mass with the kidney extending over its surface like a crescent. The tumor had invaded the kidney parenchyma throughout its upper and midportion. A portion of the tumor was found within the renal vein at the hilus. Microscopically the neoplasm was a typical hypernephroma. The spleen showed increased endothelial hyperplasia and hemosiderin deposits.

Postoperatively the patient was placed in oxygen by nasal catheter to decrease the respiratory excursions as much as possible and to supply the functioning pulmonary tissue with as much aeration as could be administered, and finally, for supportive reasons. The patient's convalescence was rapid and satisfactory. The catheter into the pleural space was removed four days postoperatively. A chest plate the day before discharge revealed pleuritis at the left base. Because of the possibility of pleural metastasis, a follow-up film five months postoperatively was taken and revealed no evidence of pathology in the chest. Repeat skull films were interpreted as showing a benign osteoma.



Post Operative Scar

The patient has returned for periodic examinations to the Out-Patient Department and has had no complaints at any time. The wound healed well and the patient has gained thirty pounds. Blood chemistry is within normal limits, the urine shows no abnormalities, and the hemogram is satisfactory.

Summary

A report of hypernephroma removed by the thoraco-abdominal approach, a relatively new procedure, has been presented. The advantages of this approach are excellent exposure and better opportunity to remove local metastatic tissue involved.

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[1]H. Mortensen—Journ. of Urology. 60-6;855 Dec. '48.
[2]R. Chute & L. Soutter—Journ. of Urology. 61-4;688 April '49.

SYMPATHETIC NERVE BLOCK

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good union of bones. Patient was given right lumbar sympathetic blocks at D12, L1 and L2 with immediate relief. A series of blocks showed that each block gave her relief for only two days and her original symptoms would return. Because there was no increase in time interval of the relief of pain following each block, it was considered wise to submit this patient to a lumbar sympathectomy for permanent relief of her causalgia. Following the operation the patient remained symptom-free.

Summary

An attempt has been made to present a short series of cases of Sympathetic Causalgia or Dystrophy with typical results following sympathetic nerve block. The results from these blocks have been gratifying. However, it is not inferred that sympathetic block should replace sympathectomy, but it is reasonable to suggest that such patients as above presented, should be given a fair trial of sympathetic blocks before surgery is considered. It has previously been reported that a sympathetic block that gives longer and longer periods of relief following each injection is a good indication that the block alone will ultimately eliminate the sympathetic condition[13]. However, if each bock gives relief for only a few hours, it is fair to assume that the condition is caused by sympathetic hyperactivity and a sympathectomy must be done to give permanent relief.

Then again, there are conditions which must be treated with sympathetic blocks alone, either because of poor operative risks or because of refusal by the patient to undertake a surgical procedure.

A sympathetic block by a competent physician is a relatively easy procedure. However, in unskilled hands, the block can be readily missed and false conclusions may be drawn from the lack of sympathetic response.

Progress has been made in this field, both in knowledge and technique, and surgeons may now have confidence in the value of diagnostic and therapeutic blocks in the hands of competent anesthetists.

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The RHODE ISLAND MEDICAL JOURNAL

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NUCLEAR THERAPY

PRESENT DAY knowledge of the release and control of atomic energy has brought civilization a previously unrecognized power over a vast new range of natural phenomena. The eventual potential of this newly gained control is beyond estimation at present but the very small part that is clearly seen holds high hopes for benefiting mankind in many fields, not the least important of which is medicine.

The development of improved methods for securing nuclear changes in the atom, producing radioactive isotopes which are now so useful in the solution of many of our biological, chemical and pathological problems, gives us a far greater scope of application of the various products of nuclear energy. This is due to the fact that large quantities of a majority of all the known artificial radioelements can now be produced and the adaptation of these substances to the medical and biological sciences falls into the tracer type of investigation and the more important therapeutic use of these agents.

The latter while as yet only meagerly explored, has demonstrated that phosphorus for example has proved valuable in the treatment of such conditions as leukemia and polycythemia vera. The use of radioactive iodine in the treatment of thyroid disease, both hyperthyroidism and certain types of thyroid cancer, has recently revealed the possibility of this agent as superseding surgery in the therapy of disturbed thyroid metabolism, fulfilling a prediction made a decade ago by Dr. Frank H. Lahey.

The present status of the value of these materials in the treatment of disease is still largely experimental. Local experience conforms with data accumulated in larger centers in that it is too early to lay down definitive procedures and rationalize therapy for specific diseases.

While the isotopes of only two elements have proved to be therapeutically useful, namely the radioisotopes of iodine and phosphorus, we are in the midst of enormous developments out of which will evolve an entirely new era of knowledge of the fundamental chemical processes of the body through employment of tracer elements provided by nuclear energy.

It seems difficult to realize that more than a decade has passed since the earliest use of activated iodine in rabbits was demonstrated by Hertz in Boston to show that the pick-up of iodine could reach a level in overactive thyroid glands several hundred times that found in normal tissues. The use of radioactive iodine was a logical sequel to these experiments so that on the basis of well established data, approximately three-fourths of all patients suffering with thyroid disease can be controlled in this manner thereby eliminating the hazards so long known to be associated with the surgical treatment of this disease.

Control of hyperthyroidism in this way is no longer open to debate, but the application of this element in the treatment of thyroid cancer presents

a much more unsettled problem since malignancy and precise methods for measuring the functional difference of cancer cells even in the thyroid, await further study.

Extended application of these newer principles of therapy to other disease entities awaits only clinical confirmation of careful experimental effort particularly in the field of cancer control whatever the site of its origin. The stimulus of present day achievements gains further impetus when it is realized how great the progress of the past half century has been since the French in 1740 established the first hospital for the exclusive treatment of patients with cancer and the British in 1802 formed in London the "Society for Investigating the Nature and Cure of Cancer."

The future holds extraordinary promise, and without engaging in speculation, it seems safe to say that the role of Nuclear Therapy with its development of isotopes from an ever increasing knowledge of atomic energy provides us with realistic hope for newer and better methods of radiation therapy in the control of malignant disease processes that will rank equally with our recent conquest of pyogenic agents through antibiotics.

A M A MEMBERSHIP AND FELLOWSHIP

THE ACTION of the House of Delegates of the American Medical Association at the San Francisco session in clarifying the issues regarding dues for AMA membership and fellowship should meet with the approval of every physician.

The necessity for annual dues had been fully established a year ago. But there was both confusion and misunderstanding regarding the assessments for membership, fellowship, and Journal subscriptions. The problem has received the attention of many state associations in the intervening year, and as a result it was resolved satisfactorily at San Francisco.

Starting in 1951 all dues paying members of the American Medical Association will receive as part of the dues a subscription to the Journal of the AMA. Presently the Journal subscription is an additional $12 to the $25 dues. Including the Journal in the dues should effect a better understanding of the work of the AMA, for many physicians who do not now subscribe to the Journal will henceforth receive issues weekly of what is beyond question the outstanding medical publication in the world.

Fellowship in the Scientific Assembly has been preserved, but the dues have been reduced from $12 to $2. Fellows may elect to take a special journal in lieu of the Journal of the AMA which they would ordinarily receive as members. This privilege, however, is not extended to members who are not Fellows of the Scientific Assembly.

EDUCATION FOR GENERAL PRACTICE

The report to the trustees of the American Medical Association by the deans of three of our major medical schools who spent two months in Great Britain studying the current status of medical education there is worthwhile reading. The committee gave particular attention to the impact that the British National Health Service is having, or seems likely to have, on medical education.

The conclusions of the committee, together with some of the major reasons for these conclusions, compile a sizeable report. One conclusion, however, warrants our attention at the moment, as it concerns the education of the general practitioner. It is reported as follows:

"Undoubtedly one development in British medical education which causes great concern has been markedly exaggerated by the National Health Service Act. That is that almost all students and recently graduated physicians want to become specialists. Even before the Act the last of the general practitioner in Britain was not too happy and today is demoralizing. We do not refer to overwork, but rather to the fact that he seems destined to a routine life which does not offer the necessary facilities to practice good medicine and which fails utterly to offer the professional incentives which lead to continued growth of the physician.

"Your committee has seen what happens when the division between specialist and general practitioner becomes decisive, and we most earnestly hope that American medical schools will carry forward the movement that has appeared since the war, and will continue to develop superior hospital training designed to prepare physicians for the general practice of medicine on an ever-enlarging scale. If we really believe that the general practitioner is the 'backbone of medicine', then let us prepare him for the most difficult task in medicine. After our experience in England we are confident that this is the most important job facing the medical schools of the United States during the next decade."

We hope that the medical schools in this country will heed this advice. We are encouraged by the general public interest, as well as professional support, of the general practitioner in the past few years. The movement to have general practice sections as part of the hospital staff, and the rapid growth of the American Academy of General Practice which requires continuing postgraduate training of its members, are movements in the right direction.

ABERRANT THYROID TISSUE

IN THE DIAGNOSIS of abnormal swellings on the tongue, or in the cervical region, or within the upper part of the thorax, it is sometimes forgotten that thyroid tissue, like adrenal, splenic and occasionally pancreatic tissue, is prone to aberrations in localization. It is well-known that retromanubrial masses of thyroid tissue are not uncommon, and that if they become sufficiently bulky they may exert sufficient pressure on the trachea to cause dyspnea. It is perhaps less well-known that small masses of aberrant thyroid tissue may occur within the trachea itself, may be situated at the base of the tongue, forming smooth, centrally-located, rounded tumors, and may occur in almost any part of the neck other than the area occupied by the normal gland. Lack of knowledge of these facts is apt to lead to errors in diagnosis and if, as occasionally happens, patients with such aberrant masses of thyroid tissue are the victims of hyperthyroidism, failure to remove the misplaced thyroid tissue may, even after a subtotal thyroidectomy, fail to relieve the symptoms of abnormal activity of the gland.

Another situation which must be considered in connection with the diagnosis of displaced thyroid tissue, because it may lead to error, is the fact that there is a type of malignant adenoma of the thyroid which histologically closely resembles normal thyroid tissue and which may metastasize to the cervical nodes or, not infrequently to bones, usually those of the cranium. One misleading peculiarity of this form of thyroid neoplasm is that the original growth in the thyroid is frequently so small that it may be overlooked. A thyroid nodule only a few centimeters in diameter may not be noted, though if the larger metastases are surgically removed their close resemblance to thyroid tissue may lead an alert surgeon to explore the gland and discover and remove the primary growth. This particular type of thyroid neoplasm is not usually highly malignant and a good many patients afflicted with it may recover after surgical intervention. One wonders whether the radioactive isotope of iodin might not possess curative value in such cases. The discussion of the subject should recall the possibility that in connection with certain glands, some of which have already been mentioned, one must never forget, particularly in solving diagnostic problems, the possibilities of enlargement or even neoplasm of aberrant tissue.

G.B.

3RD ANNUAL CANCER CONFERENCE FOR PHYSICIANS

Wednesday, October 18, 1950

R. I. MEDICAL SOCIETY LIBRARY, 106 FRANCIS ST., PROVIDENCE

MORNING SESSION

George W. Waterman, M.D., *Presiding*

10:30 a.m. CANCER OF THE LUNG
J. Gordon Scannell, M.D., Massachusetts General Hospital

11:00 a.m. APPROACH TO EXPERIMENTAL CANCER CHEMOTHERAPY
Joseph Leiter, PH.D., Bethesda, Maryland

11:30 a.m. RADIOACTIVE ISOTOPES IN CANCER DIAGNOSIS AND TREATMENT
Oliver Cope, M.D., Boston

12 noon CANCER OF THE STOMACH
Francis D. Moore, M.D., Boston

12:30 - 1:30 LUNCHEON IN BASEMENT DINING ROOM

1:30 p.m. BREAST CANCER—THE PROBLEM OF EARLY DIAGNOSIS
(Motion Picture)

* * *

AFTERNOON SESSION

Herman C. Pitts, M.D., *Presiding*

2:00 p.m. EARLY DIAGNOSIS AND TREATMENT OF BRAIN TUMORS
Arthur Elvidge, M.D., Montreal, Canada (Montreal Neurological Institute)

2:30 p.m. TUMORS IN CHILDREN
Harold W. Dargeon, M.D., New York City (Memorial Hospital)

3:00 p.m. CANCER OF ORAL CAVITY
Daniel Catlin, M.D., New York City (Memorial Hospital)

3:30 p.m. CANCER OF THE BREAST
Herbert W. Meyer, M.D., New York City (Bellevue Hospital)

4:00 p.m. ROUND TABLE DISCUSSION

BY-LAWS OF THE RHODE ISLAND MEDICAL SOCIETY

As Amended to MAY 11, 1950

RULES and BY-LAWS

ARTICLE I — NAME

The name of this organization is the RHODE ISLAND MEDICAL SOCIETY.

ARTICLE II — OBJECTS

The objects of this Society are to promote the science and art of medicine and the betterment of public health; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the problems of medicine.

ARTICLE III — MEMBERSHIP

SECTION 1. *Classes of Members.* — This Society consists of (a) Fellows, (b) honorary members, (c) and non-resident members.

SECTION 2. *Fellows.* — The Fellows are all the active members in good standing in the component societies from whom or on whose behalf the required annual dues or special assessments have been received timely by the Treasurer of this Society, and Fellows who may be elected in accordance with section 6 of the Charter.

SECTION 3. *Honorary Members.* — The honorary members are persons elected as such by the General Session on the nomination of the Council, provided, a physician resident in and practicing in Rhode Island shall not be eligible for honorary membership.

SECTION 4. *Non-resident Members.* — Any Fellow who has removed from Rhode Island and who desires to retain membership in this Society may become a non-resident member without assessment and without the privilege of voting upon notifying the Secretary, provided that his dues have been paid for the current year.

SECTION 5. *Rights of Fellows and Members.* — Fellows who are in good standing are entitled to all the rights, benefits and privileges of this Society, including the right to register at sessions of the Society, to attend and participate in the general meetings held therein, to vote, to hold office, subject to the qualifications set by these Rules and By-Laws for particular offices, to serve on committees, and to receive a copy of the Society's official publication as issued. When a Fellow resigns or loses his membership in a component society or dies he, or his estate, as the case may be, forfeits all right and title to any share in the privileges and property of this Society. The only rights possessed by honorary members and non-resident members are to register at sessions of the Society, to attend general meetings held therein, to serve on committees, and to receive a copy of the Society's official publication as issued.

SECTION 6. *Good Standing.* — A Fellow is not in good standing within the meaning of these Rules and By-Laws:

(a) Unless payment of dues and special assessments on his behalf have been received by the Treasurer as provided in these Rules and By-Laws;

(b) if he has been suspended or expelled by his component society, regardless of whether he has pending an appeal from such disciplinary order to the Council of this Society or to the Judicial Council of the American Medical Association; or

(c) if his license to practice in this or any other State has been revoked or suspended and has not been subsequently restored on appeal.

SECTION 7. *Dues.* — On or before January 1 of the year for which the dues in question are payable, each Fellow shall be assessed as annual dues such sum as the House of Delegates of this Society may have determined at its meeting in September immediately preceding. Said dues shall be paid to the Treasurer of the Rhode Island Medical Society, or to the treasurer of the Fellow's component society. The treasurer of the component society shall by the tenth of each month forward to the Treasurer of this Society dues collected from members during the preceding month. Any Fellow with respect to whom dues for that year have not been received by the Treasurer by December 31, after 60 days notice by the Treasurer shall be suspended from membership in this Society until such time as the current dues are received and the records of the Treasurer with respect to the payment of dues shall be prima facie evidence of the correctness of the facts stated therein.

Fellows having attained the age of sixty-five years shall, if they so request, be exempt from payment of dues.

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BY-LAWS

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ARTICLE IV — COMPONENT SOCIETIES

SECTION 1. *Defined.* — The component societies of this Society consist of those district medical societies which hold charters from this Society that are in full force and effect.

SECTION 2. *Charters.* — (a) All charters issued by this Society continue in full force and effect until revoked or suspended.

(b) The Council, with the approval of the House of Delegates, may charter as a component society a medical society representative of the medical profession of a county or district as circumstances may dictate or as seems desirable.

SECTION 3. *Qualifications of Members.* — Subject to the provisions of section 4 of this Article, each component society is the sole judge of the qualifications of its members and the acceptance of applicants is wholly at the pleasure of the component society. A component society may create classes or types of membership in addition to the types of membership of this Society but only such members of the component society as possess the qualifications required by these Rules and By-Laws are Fellows of this Society.

SECTION 4. *Limitations.*—Component societies are subject to the following limitations:

(a) The Rules and By-Laws of this Society, and the amendments thereto that may be adopted in the future, are the supreme law of the component societies. In so far as the Constitution or By-Laws of this Society, the Constitution or By-Laws of the component society are void and of no effect.

(b) A component society may admit to active membership or continue in such membership only such physicians as (1) are licensed to practice medicine and surgery in Rhode Island, (2) reside or practice in the territorial jurisdiction of the society, except as the Rules and Regulations of this Society may otherwise provide, (3) abide by the Code of Ethics of the American Medical Association, and (4) do not practice or claim to practice any school or system of sectarian medicine or healing.

(c) A member against whom disciplinary action has been voted by a component society shall have the right to appeal to the Council of this Society and eventually to the Judicial Council of the American Medical Association under such rules as those two bodies may adopt. However, the disciplinary action voted by the Society shall remain in full force and effect during the pendency of such appeal or appeals.

SECTION 5. The House of Delegates shall have authority to revoke the charter of any district society whose actions are in conflict with the letter or spirit of these Rules and By-Laws.

SECTION 6. *Delegates and Councilors.* — Each component society is entitled to elect one delegate to the House of Delegates of this Society for each twenty active members, or major fraction thereof, of the component society. Regardless of the total number of active members, each component society is entitled to elect at least one delegate. Only Fellows of this Society are eligible for election as delegates. The delegates shall be selected by the component societies at their respective annual meetings, for one year terms, which run from the meeting at which they were elected to the next ensuing annual meeting of the component society. Each component society is entitled to elect one Councilor and one alternate Councilor who shall be Fellows of the Society, and who shall serve two year terms beginning at the close of the annual meeting at which they are elected.

SECTION 7. *Vacancies in Offices.* — If a delegate or councilor elected by a component society dies, resigns, ceases to be a member in good standing of the Society, becomes disabled, or for any other reason cannot assume the duties of his office, or will be absent from a session of the House of Delegates of this Society, the president of the component society may appoint another Fellow to serve in his stead during the balance of the term or during the disability or absence, as circumstances may call for. As soon as practicable after the appointment, the president of the component society shall notify the Secretary of this Society of his action.

SECTION 8. *Secretaries' Duties.* — The secretary of each component society shall keep a roster of its members, grouping the members according to the type of membership held. With respect to each member, the roster shall contain the full name, address, date of birth, professional college and date of graduation, the date the member was licensed to practice in this State, and such other information as the Secretary of this Society may require. The secretary shall also keep a list of licensed physicians

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practicing within the jurisdiction of the society who are not members. In keeping such records the secretary shall note any change in the personnel of the profession by death or by removal and shall so notify the Secretary in such form as he may require. He shall promptly notify the Secretary of losses of memberships, giving the causes in individual cases.

SECTION 9. *Membership in Society of County Other Than That of Residence.* — Any doctor of medicine living on or near a county line may be elected to membership in that component society whose meetings will be most convenient for him to attend, if the action is agreeable to the component society embracing the county in which the physician resides.

SECTION 10. *Membership Where Major Office and Residence Are in Different Counties or Districts.* — Any doctor of medicine, who has his major office or professional practice in one county and resides in another county, has the option of applying for membership in the component society having jurisdiction of either county, if the action is agreeable to both affected component societies.

SECTION 11. *Transfer Cards.* — When a member in good standing in a component society moves to another county or district he shall, on request, be given a transfer card without cost. He must assume such financial obligations as shall be deemed proper by the component society to which he is transferred, and to which he makes application for membership by transfer.

ARTICLE V — OFFICERS

SECTION 1. *Officers Listed.* — The officers of this Society are the President, President-Elect, Vice President, Secretary, Treasurer, Assistant Treasurer, and the elected Councillors.

SECTION 2. *Tenure of Officers.* — The House of Delegates at its regular annual session in April shall elect the following officers to serve one year terms: President-Elect, Vice President, Secretary, Treasurer, and Assistant Treasurer. Each component society shall be entitled to elect one Councillor and one alternate Councillor to the Council who beginning at the close of the annual meeting of the component society at which they are elected shall assume office and serve until the corresponding period of the second annual meeting following their election or until their successors assume office. The officers elected by the House of Delegates shall assume office at the close of the last general meeting of the annual session at which they were elected and shall serve until the corresponding period of the annual session next following their election. At the close of the last general

meeting at the annual session next following his election, the President-Elect shall assume the office of President, and serve as such until the corresponding period of the following annual session or until his successor assumes office.

SECTION 3. *Vacancies; How Filled.* — If before the expiration of the term for which he was elected the President or the President-Elect dies, resigns, is removed, or becomes disqualified, the Vice President shall succeed to the office vacated, with all the prerogatives and duties pertaining to the office as though he had been elected President-Elect in the first instance. Vacancies created by the death, resignation or removal of other officers and vacancies and contingencies not here provided for shall be filled by appointment by the Council for the unexpired portion of the term, except in the case of vacancy in the office of an elected Councillor, the president of the component society concerned shall appoint a person to serve the unexpired portion of the term.

SECTION 4. *Qualifications.* — Only a Fellow of this Society is eligible for election or appointment as an officer.

SECTION 5. *Duties—in General.* — In addition to the rights and duties provided elsewhere in these Rules and By-Laws or as custom or parliamentary usage may require, the officers shall have the rights and duties respectively assigned to them in the succeeding sections of this article.

SECTION 6. *President.* — The following rights and duties devolve on the President: (1) to preside at all general meetings of the Society, of the Council and of the House of Delegates; (2) to deliver an address at the annual session at such time as may be arranged; (3) to act as the real head of the profession in the State and, when he deems it advisable or necessary, to visit personally, or by a representative of his own designation, the various component societies and to assist the Councillors in building up the component societies and in making their work more practical and useful; (4) to serve as a member of the Board of Trustees of the Rhode Island Medical Society Building and to appoint annually in September a Fellow of this Society as a member of the Board of Trustees to serve for a one year term beginning the following January 1; (5) to appoint annually in January to serve for a one year term delegates to other medical societies and an Anniversary Chairman to preside at the next annual dinner; (6) to appoint all committees not otherwise provided for; and (7) ex officio to serve as a member of all committees.

SECTION 7. *Vice President.* — The Vice President shall assist the President in the discharge of his duties and shall officiate for the President

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during his absence or at his request. Ex officio he shall serve as a member of the Council and of the House of Delegates and as Chairman of the Board of Trustees of the Library Building.

SECTION 8. *President-Elect.* — The President-Elect shall by active aid to the President and by membership on the Council and in the House of Delegates of which he is a member ex officio during the term of his office so conduct himself as to obtain the greatest possible acquaintanceship with the affairs and personnel of the Society so as to enable him efficiently to fulfill the office of President when he succeeds thereto.

SECTION 9. *Secretary.* — The following rights and duties devolve on the Secretary: (1) to keep minutes in separate record books of the proceedings of the general meetings of the Society, of the meetings of the Council and of the meetings of the House of Delegates; (2) to be the custodian of the Society's seal; (3) to notify members of meetings, officers of their elections, committees of their appointments and duties, and to send all notices required by these Rules and By-Laws or by order of the House of Delegates or the Council, or by law; (4) to provide for the registration of members and delegates at sessions of the Society and of the House of Delegates and to keep a record of such registration; (5) to keep a register of all component societies, their respective officers, and of all Fellows of the Society and to transmit a copy of this list to the American Medical Association, notifying the Secretary of the American Medical Association monthly as to the names of new Fellows and the names of those dropped from the Fellowship roster during the preceding month; (6) to keep a card index and register of all licensed practitioners of the state by county, noting the status of each in relation to the appropriate component society; (7) to be the custodian of all record books and papers of the Society except such as properly belong to the Treasurer; (8) to see that each Fellow is supplied with a copy of every essay published by the trustees of the Fiske or other funds; (9) to report annually to the House of Delegates; (10) to prepare and issue all programs as may be directed by the Committee on Scientific Work and annual meeting; (11) to aid the Council in the organization and improvement of the district societies and in the extension of power and usefulness of this Society; (12) to perform such other duties as may be required by the Council or the House of Delegates; (13) to be *ex officio* a member of all Standing Committees. The Secretary shall be exempt from the payment of annual dues.

SECTION 10. *Treasurer.*—The following rights and duties devolve on the Treasurer: (1) to serve ex officio as a member of the Council, of the House of Delegates, of the Board of Trustees of the Rhode Island Medical Society Building, and of the Committee on Scientific work and Annual meeting; (2) to charge on the books of the Society the dues of each Fellow and to demand and receive all funds due the Society, including bequests and donations, to deposit same in a depository approved by the Council, and to keep an accurate record thereof as well as of funds disbursed by the Society; (3) at the Council meeting in September to present to the Council, for its approval, a budget of necessary expenses of the Society for the ensuing year and to pay all bills within the scope of the approved budget; (4) to pay only on the order of the Council bills not within the scope of the approved budget; (5) under the supervision of the Council to invest the funds under his care; (6) after receiving the recommendation of the Council, to sell, mortgage, or lease any property belonging to the Society and to execute the necessary legal documents therefor; (7) when directed by the House of Delegates, to sue in the name of the Society and to prosecute such suits to final judgment and execution; (8) to subject his accounts to examination by the auditors annually; (9) to render an account of his work and of the state of the funds in his hands at the April meeting and to make in writing such other reports as the House of Delegates or the Council may require; (10) to employ such assistants as may be authorized by the Council; and (11) to give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Society.

SECTION 11. *Assistant Treasurer.* — In accordance with the Treasurer's direction or request, the Assistant Treasurer shall assist him in the performance of his duties.

ARTICLE VI — HOUSE OF DELEGATES

SECTION 1. *General Powers.* — All legislative power of the Society, is vested in and resides in the House of Delegates, which alone shall have authority to determine the policies of the Society. It shall elect (1) all the officers, (2) such delegates to the American Medical Association to which the Society may be entitled, and (3) the elected committeemen.

SECTION 2. *Composition.* — The House of Delegates shall be composed of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each twenty active members in good standing, or major fraction thereof, provided each component society shall be entitled to elect at least one delegate; and (2) the President, the President-Elect, the Vice President, the Secretary and the Treasurer.

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SECTION 3. *Conduct of Business.* — The House of Delegates in its deliberations shall be presided over by the President and in his absence by the Vice President and in his absence by the President-Elect and in his absence also by any delegate agreeable to it. Eleven delegates shall constitute a quorum for the transaction of business. The Secretary shall record the proceedings.

SECTION 4. *Time of Meeting.* — The House of Delegates shall meet in January, April, and September at such place and time as the Council may determine. The House may be called into special session at any time during the year by the President in his discretion or on the written petition of ten delegates or twenty-five Fellows.

SECTION 5. *Special Committees.* — The House of Delegates may appoint committees composed of any Fellows of the Society for special purposes or it may provide for such committees and authorize the appointment of Fellows by the President. Such committees shall report to the House of Delegates and members of such committees may participate in discussion and debate relative to their reports but unless committeemen are delegates they shall not have the right to vote.

SECTION 6. *Reporting of Proceedings.* — When the House of Delegates meets the Secretary shall cause a summary of the proceedings to appear as soon as practicable in the Society's official publication.

SECTION 7. *Election of Officers, Delegates to the American Medical Association, and Elected Committeemen.* — At its meeting in September on the even year the House shall elect a delegate and alternate to the House of Delegates of the American Medical Association, and annually at its meeting in April shall elect officers and elected committeemen. With respect to both elections, the Council shall appoint from its membership a nominating committee of five which shall prepare a list of candidates to be presented to the Council. A list of nominees approved by the Council shall be mailed to the members of the House two weeks prior to the meeting. Other nominations may be made from the floor of the House by any member of the House. All elections shall be by ballot and a majority of the votes cast shall be necessary to elect.

SECTION 8. *Memorials and Resolutions.* — No memorial or resolution can validly be issued in the name of the Society unless adopted by the House of Delegates.

SECTION 9. *Reports of Officers.* — All officers, the Council, and the chairmen of the standing committees shall prepare and submit for the consideration of the House at its April meeting reports in writing concerning their activities during the past year.

SECTION 10. *Fixing of Annual Dues.* — The House at its September meeting shall determine and fix the dues for the ensuing fiscal year.

ARTICLE VII — THE COUNCIL

SECTION 1. *General Powers.* — The Council shall carry out the mandates and policies of this Society as determined by the House of Delegates or by referendum or initiative measures. Subject only to the provisions of (1) these Rules and By-Laws, (2) resolutions or enactments of the House of Delegates, and (3) measures initiated at the general session, the Council has full and complete power and authority to perform all acts and to transact all business for the Society and to manage and conduct all of the property, affairs, work and activities of the Society.

SECTION 2. *Composition.* — The Council shall consist of the Councillors elected by the component societies, the five most recent living past Presidents of the Society, the President, the President-Elect, the Vice President, the Secretary, the Treasurer, and the Assistant Treasurer.

SECTION 3. *Meetings.* — The Council shall meet bimonthly at such time and place as the President may determine. The President may call a special meeting of the Council on his own motion and must call a special meeting on the written request of three members of the Council. Five members shall constitute a quorum. The President shall preside at meetings of the Council and, in his absence, the Vice President and President-Elect in order. The Secretary shall keep a record of its proceedings.

SECTION 4. *Duties.* — In addition to the duties and powers conferred on the Council elsewhere in these Rules and By-Laws, the Council shall act as the arbiter of the Society with respect to matters of ethics and questions involving the rights and standing of Fellows, whether in relation to other Fellows, to the component societies, or to this Soci-

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ety. When its jurisdiction is invoked as hereinafter provided it shall review instances in which disciplinary orders or measures have been adopted by a component society against a member.

SECTION 5. *Appeals and Disciplinary Proceedings.* — A member of a component society censured, suspended, expelled, or otherwise disciplined by his component society may appeal to the Council within two months following the date of such disciplinary order for a determination of applicable questions of law and procedure but not of fact. Appeals shall be in writing and be filed with the Secretary of the Society. On the filing of an appeal the Secretary shall notify other members of the Council. Appeals shall be heard by the Council only after reasonable notice in writing of not less than ten days of the time and place of the hearing on the appeal has been given to the appellant member and the president and secretary of the component society. In every case of an appeal the Council, prior to any hearing on the appeal shall exert all proper efforts at conciliation and compromise. The decision of the Council shall be final and bind the appellant member and the component society unless the matter is carried timely to the Judicial Council of the American Medical Association.

SECTION 6. *Report to the House of Delegates.* — The Council at each session of the House of Delegates shall make a report concerning the state of the Society and the work and proceedings of the Council during the interval since the last session of the House.

SECTION 7. *Compensation of Officers and Employees.* — The Council shall fix the compensation of the officers, representatives and employees of the Society.

SECTION 8. *Executive Secretary.* — The Council may employ an Executive Secretary of the Society after authorization by the House of Delegates.

ARTICLE VIII — SESSIONS AND MEETINGS

SECTION 1. *Sessions of the Society.* — The Society shall hold an annual session at such place and at such time as the House of Delegates may determine. The Secretary shall give to each member at least seven days' notice of such annual session.

SECTION 2. *General Meetings.* — During the annual session there shall be held at least one general meeting open to all registered members and guests. The general meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and to the public. The general meeting by a two-thirds vote of the Fellows present may order a general referendum on any question pending before the House of Delegates and when so ordered the House of Delegates shall submit such question to the Fellows of the Society by ballot sent by mail. A majority of such votes shall determine the question and be binding on the House of Delegates. The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum in the above-specified manner, and it shall be bound by the results. The general meeting may receive and vote on resolutions introduced at any session but the resolutions shall not be binding on the Society until approved by the House of Delegates.

SECTION 3. *Special Sessions.* — A special session of the Society may be called by the President in his discretion and must be called by him on the written petition of twenty-five Fellows.

SECTION 4. *Right of Members to Participate In.* — All members of the Society may attend and, except as otherwise limited, may participate in the annual session held by the Society, subject only to such reasonable parliamentary rules as may be adopted. Members may also attend meetings of the House of Delegates, except when the House of Delegates is in executive session. Except with

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the consent of the House of Delegates, however, no member not a delegate may have the privilege of the floor.

SECTION 5. *Registration Required.* — Before a member can attend and participate in proceedings or activities of the annual sessions he must register, under such procedure as the Secretary may prescribe.

SECTION 6. *Guests.* — The privilege of attending the annual session may be extended to guests under such conditions as the Secretary may determine.

SECTION 7. *Length of Papers or Addresses.*— No address or paper read before a general or section meeting, except those of the President and invited guests, shall occupy more than thirty minutes in its delivery. In the discussion following a paper or address at such a meeting no member shall be permitted to speak longer than five minutes on any subject without general consent.

SECTION 8. *Property and Papers.*—The authors of all papers and addresses presented before this Society shall be requested to deposit them with the Secretary for publication in the official Journal of the Society.

ARTICLE IX — FINANCE

SECTION 1. *Raising of Funds.*—Funds for conducting the affairs of the Society may be raised (1) by such annual dues from Fellows of this Society as the House of Delegates may determine at its September meeting; (2) by such special assessments on members as the House of Delegates may determine; (3) by voluntary contributions, devises, bequests, and other gifts; and (4) in any other manner approved by the House of Delegates.

SECTION 2. *Fiscal Year.* — The fiscal year of this Society is from January 1 to December 31 inclusive.

SECTION 3. *Supervision.* — Supervision of the funds, investments, and expenditures of the Society is vested in the Council. The Council shall receive the audited accounts of the Treasurer and of other agents of the Society and present a statement of those accounts in its annual report to the House of Delegates. It shall pass on the sufficiency of the bond given by the Treasurer. It shall report on all resolutions appropriating money and shall submit such report to the House of Delegates for authorization or approval. At the meeting of the House of Delegates in September the Council shall submit a budget for the expected income and expenses of the Society for the ensuing year. If it approves the House of Delegates shall make the necessary appropriations and impose such conditions on the expenditure of the funds so appropriated as it sees fit, provided, in the case of an emergency the Council may authorize the expenditure of funds for items not mentioned in the budget for that year.

ARTICLE X

STANDING COMMITTEES AND BOARDS OF TRUSTEES

SECTION 1. *Names.* — The standing committees of the Society shall be the following: Committee on Scientific Work and Annual Meeting, Committee on Public Laws, Committee on Publication, Committee on Postgraduate Education, Committee on Medical Economics, Committee on Industrial Health, Committee on the Library, Committee on Public Relations and Policy, Trustees of the Rhode Island Medical Society Building, Trustees of the Caleb Fiske Fund, Trustees of the Special Funds, Auditors.

SECTION 2. *Required Reports.* — Each of these committees shall at the April meeting of the House of Delegates report in writing concerning its activities during the past year. The Trustees of the Caleb Fiske Fund and the Trustees of the Special Funds shall report to the Council.

SECTION 3. *Vacancies.* — If an elected committeeman dies, resigns, is removed or fails to serve, the Council shall appoint some Fellow of the Society to serve until the next session of the House of Delegates at which time the House shall elect some Fellow of the Society to serve for the unexpired portion of the term.

SECTION 4. *Scientific Work and Annual Meeting.* — The Committee on Scientific work and Annual meeting shall consist of the President, the Secretary, and the Treasurer, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall determine the character and scope of the scientific proceedings of the Society for each session, subject to instruction of the House of Delegates. It shall be the duty of the Committee

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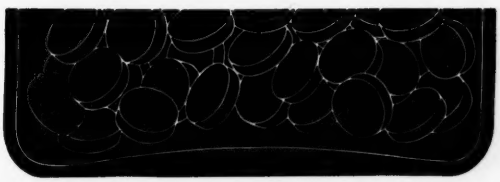

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THE CARE OF HAND INJURIES

The 5th of a series of articles prepared by the American Society for Surgery of the Hand, and distributed by the Committee on Trauma, American College of Surgeons

V

FRACTURES AND DISLOCATIONS

I *Protection of the Hand* (Abstract of Article I)

The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function.* No attempt should be made to examine, cleanse or treat the wound until operating room facilities are available.

II *Requirements of Early Definitive Treatment* (Abstract of Article II)

Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking definitive treatment, the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia and a bloodless field. Treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, the repair of injured structures, protecting nerves, bones and tendons and providing maximum skin coverage and the application of firm protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

III *Surface Injuries* (Previously circulated)

IV *Lacerated Wounds* (Previously circulated)

V *Fractures and Dislocations*

The purposes of treatment of closed fractures and dislocations of the bones of the hand are:

1. Protection of the injured bony structures from further displacement and avoidance of added damage to soft parts.
2. Restoration of normal relations of the bony structures.
3. Maintenance of the corrected relation of the bones to permit healing, at the same time avoiding stiffening in position of nonfunction.
4. Restoration of function.

These objectives are sought in the various stages of treatment.

1. First-aid treatment
   a. Avoid manipulation or attempts at reduction until skilled attention is available and accurate diagnosis has been made.
   b. Prompt protection of the hand by complete immobilization in the position of function pending definitive treatment.
2. Definitive treatment.

When proper skill and facilities are available, this consists of:

a. Diagnosis by means of
   1—Inspection to determine swelling, ecchymosis, deformity, loss of function.
   2—Palpation, gently employed, to discover bony irregularity, point of maximum tenderness, referred pain. This sign is of importance in discovering fractures of the long bones, particularly where deformity may not exist or is concealed by swelling. Gentle pressure in the line of axis of the long bone will result in pain at the fracture site.
   3—X-ray examination. Obligatory where fracture or dislocation is suspected. Injuries in the region of the carpus require not only antero-posterior and lateral views but two or more oblique views in addition. Fractures of the carpal bones frequently fail to show in antero-posterior and lateral views.

b. Reduction. Restoration of normal position of bony structures should be secured at the earliest possible time by:
   1—Manipulation.
   Whether reducing a fracture or a dislocation, full relaxation, preferably

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*Position of function or position of grasp: wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted, slightly forward from hand and slightly flexed.

CARE OF HAND INJURIES

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under general anesthesia, is desirable. Manual traction, pressure and moulding should be gentle and deliberate to avoid further soft-part injury.

When attempts at reduction by manipulation are not promptly successful under these conditions, they should be abandoned in favor of open (operative) replacement. Dislocation at the metacarpophalangeal joint of the thumb will almost invariably require open reduction.

2—Skeletal control.

To maintain reduction, particularly of oblique or comminuted fractures of phalanges or metacarpals or fractures into joints, control by skeletal fixation may be required. This may be applied by means of a length of thin Kirschner wire inserted transversely through the distal end of the fractured bone or through the terminal phalanx of the finger. The hand and injured finger or fingers should be supported in the position of function on a palmar moulded curved form or ball splint. This alone will ordinarily suffice to maintain proper position after reduction by manipulation. When control by skeletal fixation is required for maintenance of reduction, the transfixing wire may be connected to this splint on its palmar aspect or to a projecting frame, at or above wrist level, by elastic bands. Fixation or traction by means of a hole in the finger nail, or by adhesive applied to the finger, or by woven constricting device is not satisfactory. Continued straight traction on the fingers in the extended position is to be avoided.

3—Open reduction.

When manipulation fails to produce satisfactory reduction, open operative reduction is to be employed. This requires careful preliminary skin preparation and should be carried out under optimum operating conditions as described in II (Requirements of Early Definitive Treatment).

3. Maintenance of reduction.

Immobilization of bony injury following reduction should:

(a) Be secured with firm, even pressure bandaging, permitting no motion at site of injury.

(b) Be nonconstricting, not interfering with circulation.

(c) Be comfortable, causing no excess pressure.

(d) Preserve, as far as possible, the position of function, taking into account the normal concavities of the palmar surface of the skeletal structure (arches of the hand) and flexor surface curves of the phalanges. (Wrist in 30° dorsiflexion, metacarpophalangeal and distal interphalangeal joints in 45° flexion and middle interphalangeal joint in 90° flexion.) Flat splinting is to be condemned.

(e) Leave free to move all joints whose motion will not jeopardize position and healing. During immobilization, active motion of all joints not necessarily confined is to be encouraged.

Immobilization may be accomplished by:

(1) Splinting or plaster casting, applied as described in 2 B Reduction.

(2) Internal fixation. Kirschner wires may be employed, following either open or closed reduction, as axial intramedullary splints for individual long bones (not to protrude into a joint); as transversely introduced fixation pins passing through adjacent bones to secure the fragments of metacarpal fractures; as penetrating fixation for fragments of carpal fractures.

Wiring or plating of fractures of the bones of the hand is generally unsatisfactory.

During the early period of immobilization, elevation of the hand is desirable. Immobilization of the injury should be consistent and continuous until healing and firm union have been established.

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CARE OF HAND INJURIES

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Healing of ligamentous injuries accompanying dislocations requires two weeks of immobilization following reduction.

Healing of fractures of the long bones requires immobilization for three to five weeks.

Healing of carpal bone fractures requires twelve to fourteen weeks' immobilization. Fractures of the navicular may require four months to unite. If immobilized consistently for this length of time, most of these fractures will not require surgical intervention.

4. Restoration of function.

During the healing process, all joints not necessarily immobilized should be freely moved to activate their controlling muscles and their use by the patient encouraged.

Following establishment of healing or firm union, restoration of function is secured by directed active motion, particularly through the means of exercise and occupational therapy.

SYMPATHETIC NERVE BLOCK

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to provide a suitable place and to make all necessary arrangements for each meeting of the Society. The Committee shall prepare and issue at least seven days previous to each session a program announcing the order in which papers, discussions, and other business shall be presented.

SECTION 5. *Public Laws.* — The Committee on Public Laws consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall keep itself informed with respect to laws, court decisions, court proceedings, administrative rules, and proposed and pending legislation relating to public health and such other matters as relate to the objects of the Society.

SECTION 6. *Publication.* — The Committee on Publication consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall arrange for the publication and distribution and have charge of all the Society's publications. Expenses of the Committee must be authorized by the Council, and subsequently reported to the House of Delegates. All receipts shall accrue to the Treasurer.

SECTION 7. *Postgraduate Education.* — The Committee on Postgraduate Education shall consist of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall act in conjunction with the Council to provide postgraduate clinics, courses and other instruction for the component societies and the Fellows of this Society.

SECTION 8. *Medical Economics.* — The Committee on Medical Economics consists of the President and the Secretary ex officio and nine (9) members elected by the House of Delegates. The committee shall be charged with the duty of studying and investigating, so far as it and the Council may deem practicable or advisable, such phases of general economics as have a bearing on the practice of medicine.

SECTION 9. *Industrial Health.* — The Committee on Industrial Health shall consist of the President and the Secretary ex officio and nine (9) members elected by the House of Delegates. The Committee on Industrial Health shall keep itself informed concerning: (1) actual conditions and practices in industry affecting or relevant to the health and well-being of industrial workers; (2) the medical care rendered as a result of industrial accidents or occupational diseases; and (3) legislation pertinent to the field of industrial health.

This committee shall also study, determine, and advocate such measures, and laws as in its judgment will improve the welfare of the industrial worker. Such a committee shall cooperate with other agencies having a legitimate interest in the health of industrial workers. It shall coordinate its activities, so far as possible, with the activities of the Council on Industrial Health of the American Medical Association.

SECTION 10. *Library.* — The Committee on the Library consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall have charge of the Library of the Society and shall have custody of all books and pamphlets published by the Society and the Trustees of the Fiske Fund. It shall appoint some suitable person Librarian, the amount of whose compensation shall be approved by the Council, shall make rules concerning the use of the Library. The Librarian shall keep a list of all additions to the Library, shall see that the Library is open for reference at such hours as the Committee may direct, shall compile the necessary catalogs and reference lists, shall loan books from the Library only on receipts, and shall perform such other duties as may be assigned by the Committee.

SECTION 11. *Public Policy and Relations.* — The Committee on Public Policy and Relations shall consist of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall concern itself with all matters of public policy, public relations, education and information relative to medicine and public health.

SECTION 12. *Rhode Island Medical Society Building.* — The Board of Trustees of the Rhode Island Medical Society Building consists of seven members as follows: the Vice President, who shall be chairman, the chairman of the Library Committee, one person elected by the Providence District Society, one person not a member of the Providence Society, who shall be appointed by the President, the President, the Secretary, and the Treasurer. The Committee shall have charge of the Library building, shall appoint some suitable person janitor, assign him his duties and fix his compensation, but the amount must be approved by the Council. Through the budget of the Treasurer this Committee shall recommend to the Council the amount necessary for the maintenance of the building. Other expenses of the Committee must be authorized by the Council, which expenditures must subsequently be reported to the House of Delegates.

SECTION 13. *Auditors.* — The House of Delegates shall at its April meeting elect an Auditor to serve a two-year term. A member to be eligible for election or appointment as an Auditor must not have served in such capacity for the Society within the preceding year. The Auditors shall annually make careful examination of the Treasurer's books and vouchers and make a report of their findings to the Council.

SECTION 14. *Caleb Fiske Fund.* — The President, the President-Elect, and the Vice President shall be the Trustees of the Caleb Fiske Fund.

SECTION 15. *Other Special Funds.* — The President, the Secretary and the Treasurer shall be the Trustees of such special funds as have been created and may be created hereafter, provided other Trustees are not designated by the creators of the funds or appointed by the House of Delegates.

ARTICLE XI
DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

SECTION 1. *Selection and Terms.* — The House of Delegates at its September meeting on the even year shall elect a delegate and alternate to the House of Delegates of the American Medical Association, in conformity with the applicable provisions of the Constitution and By-Laws of the American Medical Association.

SECTION 2. *Assumption of Office.* — The Delegate and alternate shall assume office on January 1 of the year succeeding their election, for two year terms, and shall serve until their successors are elected and assume office.

SECTION 3. *Vacancy During Elected Terms; How Filled.* — If before the termination of his term the delegate dies, resigns, ceases to be a member in good standing of this Society, becomes disabled or for any other reason cannot assume or continue to assume the duties of his office or will be absent from a session or meeting of the House of Delegates of the American Medical Association, the rights and duties of the office devolve on his alternate for the time being or for the remainder of the term as circumstances, in the opinion of the Council, may indicate.

ARTICLE XII — ETHICS

The Code of Ethics of the American Medical Association in force at the time of the adoption of these Rules and By-Laws and as it may from time to time thereafter be amended by the American Medical Association shall govern the conduct of members of this Society in their relation to each other and to the public.

ARTICLE XIII — OFFICIAL PUBLICATION

The official publication of this Society is the Rhode Island Medical Journal, in which shall be published all official Society notices and transactions of the House of Delegates, the general meetings of the Society, and abstracts of the meetings of the Council.

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PRINCIPLES OF MEDICAL ETHICS

The recently revised Code of Ethics of the American Medical Association is being reprinted for the general information of the membership.—[Ed.]

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

Chapter I

General Principles

Character of the Physician

Section 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

The Physician's Responsibility

Sec. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

* Sir Thomas Watson.

Groups and Clinics

Sec. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

Advertising

Sec. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or instituion has been, or is, concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

Educational Information Not Advertising

Sec. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of

cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

Patents, Commissions, Rebates and Secret Remedies

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

Evasion of Legal Restrictions

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

Chapter II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

Standards, Usefulness, Nonsectarianism

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

*Nicon, Father of Galen.

Patience, Delicacy and Secrecy

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

Prognosis

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

The Patient Must Not Be Neglected

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

Chapter III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSIONS AT LARGE

ARTICLE I — DUTIES TO THE PROFESSION

Upholding the Honor of the Profession

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

Membership in Medical Societies

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

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Safeguarding the Profession

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II — PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

Dependence of Physicians on Each Other

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

Compensation for Expenses

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

One Physician in Charge

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III — DUTIES OF PHYSICIANS IN CONSULTATIONS

Consultations Should Be Encouraged

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

Consultation for Patient's Benefit

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

Punctuality

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful: he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

Patient Referred to Consultant

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

Discussions in Consultation

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

Responsibility of Attending Physician

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However,

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after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

Conflict of Opinion

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

Consultant In Attendance

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV — DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

Misunderstandings to be Avoided

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

Social Calls on Patient of Another Physician

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

Services to Patient of Another Physician

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

Criticism to be Avoided

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

Emergency Cases

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

Precedence When Several Physicians Are Summoned

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish someone other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A Colleague's Patient

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

Substitution in Obstetric Work

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V — DISPUTES BETWEEN PHYSICIANS

Arbitration

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI — COMPENSATION

Limits of Gratuitous Service

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

Conditions of Medical Practice

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

Contract Practice

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

Free Choice of Physician

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

Commissions

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

Purveyal of Medical Service

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

Chapter IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

Physicians as Citizens

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

Public Health

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk of his own health.

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

Conclusion

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

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ARTICLE XIV — RULES OF ORDER

In the absence of any provision in these Rules and By-Laws to the contrary, all general meetings of the Society and all meetings of the House of Delegates, of the Council, and of Committees shall be governed by the parliamentary rules and usages contained in the then current edition of Robert's "Rules of Order."

ARTICLE XV — AMENDMENTS

These Rules and By-Laws may be amended in any general meeting of the Society by a majority vote of the Fellows present and voting, provided the proposed amendment has been presented to the House of Delegates and has received its approval.

ARTICLE XVI

REPEAL OF PREVIOUS RULES AND BY-LAWS AND MOTIONS

On the adoption of these Rules and By-Laws (1) all previous Rules and By-Laws and (2) motions of record and rules and regulations in conflict with these Rules and By-Laws are hereby repealed, provided that all officers, delegates, and elected committeemen now in office shall continue their incumbency until their successors are duly elected as provided in these Rules and By-Laws.

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